Texas Department of Insurance

Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VICENTE JUAN MD
1425 SANTA FE
CORPUS CHRISTI TEXAS 78404

Respondent Name	**Carrier's Austin Representative Box**
TEXAS MUTUAL INSURANCE CO	Box Number 54
MFDR Tracking Number	**MFDR Date Received**
M4-07-0750-01	April 26, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary along with the DWC60 request.

Amount in Dispute: $8,870.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the service represented by CPT code 49010 is a secondary procedure, therefore, it is improper to bill this procedure with modifier '-65'. 04/01/96 TWCC Medical Fee Guideline, Surgery Ground Rule, Modifiers, -65 is defined in part as, 'Co-Surgeons...Each surgeon's primary procedure shall be identified by adding the modifier '-65' to the procedure code....' It is this carrier's position that the documentation does not support that a vertebral corpectomy (CPT code 63090) was performed. It is this carrier's position that the unlisted procedure (22899) is not documented. However, assuming for the sake of argument it is documented, it has to be a secondary procedure. As enumerated earlier, it is improper to bill a secondary procedure with modifier '-65'."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2003	63090-65, 22558-65, 49010-65, 22899-65	$8,870.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Per 28 Texas Administrative Code §134.201(a), effective April 1, 1996, 21 Texas Register 2361, "The commission adopts by reference herein, the Texas Workers' Compensation Commission Medical Fee Guideline 1996. The Guideline shall be effective for all medical treatments, services, durable medical equipment and pharmaceuticals provided on or after April 1, 1996.

2. This request for medical fee dispute resolution was received by the Division on April 26, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 28, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
4. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 26, 2004
   - JF – Documentation submitted does not substantiate the service billed
   - YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
   - YD – Duplicate appeal. An appeal of the original audit decision was previously performed for these services. If you disagree with the original appeal decision, you may request medical dispute resolution through the Texas Workers' Compensation Commission.
   - 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
   - 24 – A charge was made for an independent or separate procedure on the same date as other related services.
   - JM – Accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed Is invalid. Please refer to the applicable medical fee guideline and/or Medicare guideline for the correct code or modifier for the services rendered.
   - YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed. The primary surgeon, Dr. John Masciale, billed only code 22558 with modifier -65 based on the documentation it appears the approach was performed by Dr. Juan after the approach was performed, it appears Dr. Juan assisted. The correct modifier for assistant is -80. Modifier -65 is to be used on each surgeon's primary procedure only.

Issues

1. Did the requestor meet the requirements of DOP?
2. Did the requestor document and append the correct modifier to the surgical procedure?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.201, Surgery Ground Rule, sets out the reimbursement amounts for the following CPT codes"
2. Review of the submitted documentation documents that the requestor billed using modifier -65. Per 28 Texas Administrative Code §134.201, Surgery Ground Rule Modifiers section states "-65 Co-Surgeon: If two surgeons each perform separate procedures through the same incision, the total value for each surgeon's primary procedure shall be reimbursed at 75% of the MAR for each primary surgical procedure. Each surgeon's primary procedure shall be identified by adding the modifier '-65' to the procedure code. DOP is required." The requestor appended modifier -65 to CPT codes 63090, 22558, 49010 and 22899.
3. Review of the operative report dictated by John Masciale, MD documents the following surgical procedure:
   - Retroperitoneal approach to the lumbar spine
   - L4 partial corpectomy with radical anterior L4 discoidectomy
   - Anterior lumbar interbody fusion at L4
   - Internal fixation at L4 with LT titanium fusion cages with BMP
4. Review of the operative report dictated by Vicente Juan, MD documents the following surgical procedure:
   - Retroperitoneal approach to the lumbar spine with L4-L5 radical diskectomy
   - L4 partial corpectomy
   - Interbody fusion at the L4-L5 space with two titanium fusion cages and bone morphogenic protein

5. The requestor has not meet the documentation requirements for billing with modifier -65, therefore additional reimbursement cannot be recommended.
6. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in

the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission. The requestor billed CPT code 22899-65. CPT code 22899 is identified in the medical fee guideline as a DOP code – unlisted procedure of the spine.

7. Per Medical Fee Guideline 1996, General Instructions III A, "Documentation of procedure (DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill. DOP is used when the services provided are not specifically listed or are unusual or too variable to have an assigned MAR. The required documentation may vary based on the complexity of the procedure. DOP shall include pertinent information about this procedure including: 1. Exact description of procedure or service provided; 2. Nature, extent, and need (diagnosis and rationale) for the service or procedure; 3. Time required to perform the service or procedure; 4. Skill level necessary for performance of service or procedure; 5. Equipment used (if applicable); and 6. Other information as necessary."

8. Medical Fee Guideline 1996, General Instructions VI provides that "CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate. HCPCS codes shall be reimbursed as provided in the DME Ground Rules. In the event of a dispute, fair and reasonable shall be determined by the Commission in accordance with the Texas Worker's Compensation Act and Commission rules and procedure

9. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission."

10. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

11. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that.

    - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT codes 22899-65.
    - Documentation of the comparison of charges to other carriers was not presented for review.
    - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
    - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
    - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

    The request for additional reimbursement for CPT code 22899-65 is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

<u>Authorized Signature</u>

		February 15, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the** *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.